| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005011 | A. BUILDING: _____ B. WING _____ | 10/07/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARION GENERAL HOSPITAL | 441 N WABASH AVE MARION, IN 46952 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>Surveyor: 33212<br>Facility Number: 00005011<br><br>Type of Survey: State Licensure Off Site HFAP Accreditation Survey<br><br>Date of HFAP On Site Survey - Hospital full survey 10/5-7/2015<br><br>Date of ISDH off site review - 3/01/2016<br><br>Based on review of the April 4 - 6, 2015 HFAP Accreditation Survey Report, it has been determined that Marion General Hospital meets the requirements for Hospital Licensure in Indiana for 2015. | S 000 | | |